CASE REPORTS

- **Unusual Scrotal Lipoma Associated with Sigmoid Diverticulum**
- **"Polyp" of the Prostate Protruding into the Rectum**
- **Resection of Recurrent Carcinoma of the Esophagus**
- **Diagnosis of Subdiaphragmatic Abscess by Needle Biopsy of the Liver**
- **Pulmonary Paraffinoma Verified at Thoracotomy**

Unusual Scrotal Lipoma Associated with Sigmoid Diverticulum

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LIPOMAS ARE VERY COMMON TUMORS and may occur in any part of the body but are seldom found in the inguinal area and even more rarely in the scrotum.

Most scrotal lipomas are attached to the spermatic cord. The site of origin often is not determined. They are usually benign but may become malignant. Symptoms are caused generally by the size, weight and pressure of the growth. There is wide variance in the weight reported for lipomas of the scrotum: Livermore,[4] in a compilation of reports by a number of observers[2, 3, 7, 8, 9, 10] quoted weights from 225 gm. to over 9 kg.

Lipoma of the inguinal canal usually simulates inguinal hernia, with which it may be associated. Watson[11] noted that most such tumors are attached to the spermatic cord or sac near the internal ring. Diagnosis in most cases is very difficult, especially if the tumor is noted suddenly after a strain and is associated with nausea and vomiting. A number of cases have been reported[1, 5, 6] in which a diagnosis of hernia was erroneously made and hernia belts or trusses were worn until the tumor was observed at operation. It has been postulated that small fatty particles about the spermatic cord break through the tunica and coalesce with preperitoneal fat, intra-abdominal pressure then thinning the fascia and forcing the lipoma as a wedge through the fascial planes or the inguinal canals.

REPORT OF A CASE

A 49-year-old man had undergone operation seven years before for repair of a right indirect inguinal hernia, which recurred five years later. Meanwhile a mass in the left groin had developed two years after the operation and had increased in size until it caused some distress on straining at bowel movement and at work. The only other symptoms reported were an occasional feeling of gas pressure in the lower left quadrant of the abdomen and an uncomfortable but not painful sensation of pressure in the left side of the scrotum. The patient had worn a double truss for five years.

On physical examination a large, soft mass was noted in the right inguinal canal; the external ring was small and there was no propulsion through the ring on straining. The left external ring was large enough to admit two fingers, and a mass was palpated in the canal which came down to but not through the ring on straining. The vas deferens, testicle and epididymis on the right were normal; the left testicle and epididymis were of normal size and consistency, but in the upper portion of the scrotum there was a firm, nodular mass which appeared to be inseparably attached to the spermatic cord and was tender to palpation. It was not translucent. A urologist who was consulted believed that the mass probably was a fibroma of the cord but might be a malignant tumor.

In April 1952 the patient was admitted to hospital for elective operation for repair of bilateral hernia.

At operation the right direct inguinal hernia was repaired by the McVey technique. The left inguinal canal was opened in the usual manner and the inguinal sac was freed from the vas deferens and other vessels by combined sharp and blunt dissection. The sac was attached to the spermatic cord by thin connective tissue. It was 11 cm. long and 2 mm. thick. The neck of the sac was 3.5 cm. wide. Bulging through the neck of the sac was a diverticulum of the sigmoid colon approximately 5 cm. long, 2.5 cm. in width and 3.0 cm. in depth. Extending from the base of the diverticulum and attached to the posterior surface of the sac was a hard fibrous cord about 3.0 mm. in diameter extending the entire length of the sac and terminating in two adjoining papillary masses, each approximately 2.0 by 1.5 by 1.5 cm. in size, which were tightly attached to the inner surface of the sac at the most distal point.

The inguinal sac with the attached cord and tumors was excised at the neck; the diverticulum was excised and the opening into the sigmoid closed. The neck of the sac was sutured and fastened beneath the internal oblique muscle, and the hernia was repaired by the McVey technique.

Pathologist's report: The masses, polypoid in appearance, were composed of yellowish-gray tissue which on microscopic section was seen to be mature fat cells, some proliferative especially at the margins of the masses. In some spots the fat was necrotic. The lipoma had a distinct fibrous capsule and a few fibrous septa. Pronounced proliferation of fibrous tissue was noted in some areas of the wall of the sac, with numerous fibroblasts. No evidence of malignant change was observed.

COMMENT

Because of the peculiar attachment of the lipoma to the side and the distal end of the inguinal sac and to the diverticulum, it is believed that the hernia was of pulsion type and was caused by weight of the lipoma pulling the diverticulum into the inguinal canal. The author has noted no other published report of a lipoma originating from a diverticulum.

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"Polyp" of the Prostate Protruding Into the Rectum

Thirty-Eighth Reported Case of Leiomyoma of the Prostate

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BENIGN PROSTATIC ENLARGEMENT or a prostatic neoplasm frequently is diagnosed by rectal examination. Rarely observed, however, is the phenomenon in the present case: A lesion that seemed, on palpation, to be a discrete rectal polyp was found to originate in the prostate.

REPORT OF A CASE

A 48-year-old white man admitted to hospital for the operative repair of a left inguinal hernia, had no complaints referable to the urinary tract or the bowel. On rectal examination a hard, smooth-surfaced pedunculated non-tender mass about 2 cm. in diameter was palpated. It seemed to be attached to and to arise from the anterior rectal wall. Upon proctoscopic examination it was observed that the "polyp" apparently arose from extrinsic structures and was pushing into the rectum. No evidence of disease was seen in an excretory urogram or in a cysto-urethrogram.

The prostate was exposed through a perineal incision and it was seen that the lesion that had been palpated rectally was a pedunculated tumor arising from the prostate and pushing into the rectum (see Figure 1). It was easily excised from the prostate, which looked and felt normal.

Pathologist's report: The specimen, a hard encapsulated tumor, was 3 cm. in diameter. The surface of the cut section was a pale grayish white.

Upon microscopic examination of sections (see Figure 2) the tumor was observed to be composed of solid interlacing bundles of smooth muscle fibers, the stroma being composed of strands of connective tissue. The pathological diagnosis was leiomyoma of the prostate.

From the Urology Section of the Surgical Services, Veterans Administration Hospital, San Francisco 21, California.

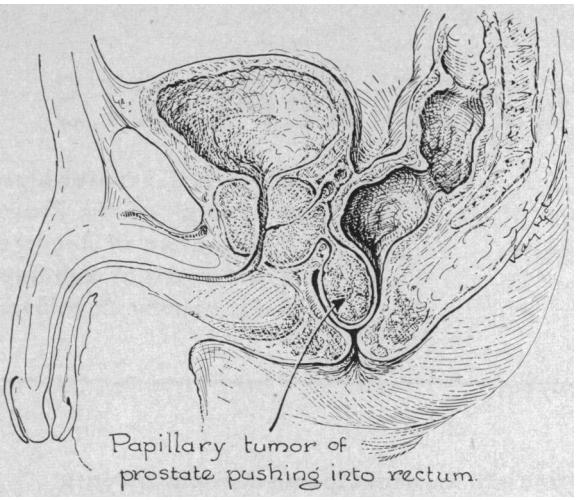

Figure 1.—Diagram showing the pedunculated prostatic tumor protruding into the rectum.

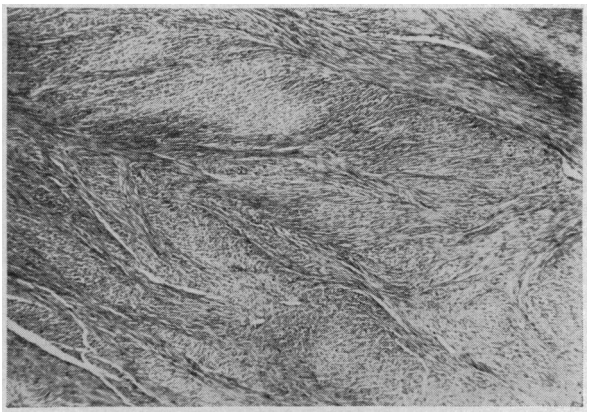

Figure 2.—Low power photomicrograph of the leiomyoma.

DISCUSSION

This case of leiomyoma of the prostate is the thirty-eighth such case of record.[1] McIntyre,[4] in a review of the previously reported cases, noted that in most instances the primary symptoms were referable to the urinary tract. However, in 11 cases, as in the case reported here, the tumor protruded into the rectum[3] or perineum.

There has been no report of recurrence after adequate surgical removal.[2]

SUMMARY

A case of a pedunculated prostatic tumor protruding into the rectum is presented. The tumor was a leiomyoma, and the case is the thirty-eighth reported case of leiomyoma of the prostate.

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